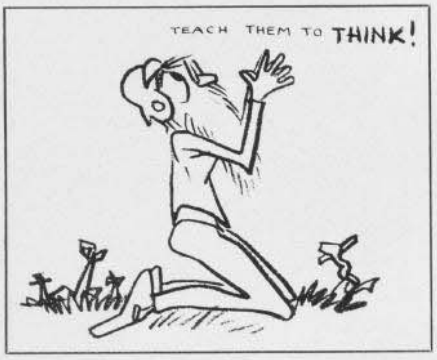
GRAMPAW PETTIBONE



Ferry Accident

Two SBD–4 ferry pilots filed a contact flight plan at 1324, based on a 1230 weather report. Departure was not made until 1 hour later, however, during which time another weather report had been issued, showing weather along their route to be below contact requirements. Upon reaching this low-ceiling area, the pilots left the airways route and attempted to reach their destination via a mountain pass. The weather got progressively worse and both pilots crashed.

Grampaw Pettibone says

The initial flight clearance in this case was proper, but a closer and more solicitous supervision of flight operations at the air station concerned should have prevented this flight from taking off after the adverse weather report was received.

There are two distinct lessons for ferry pilots in this case: 1. the 1230 weather report, although satisfactory for contact clearance, showed a rather low ceiling; therefore, the latest weather report should have been checked prior to departure, and 2. upon reaching the low-ceiling area, the pilots should have turned back and landed at the nearest airport in accordance with regulations, instead of proceeding into a mountainous area. Even without such regulations, good judgment should have dictated this latter course.

Buaer Circular 14–33 contains the latest instructions on the ferrying of naval aircraft. In the interests of safety, ferry flights have been limited to daylight flights, under contact conditions only, and over established civil airways insofar as practicable. Civil Air Traffic Regulations are effective on all flights over civil airways routes and should be thoroughly understood by all pilots concerned.

Remember, the main objective of all ferry flights is safe delivery of the airplane!

Pilot to Blame for Stalls

NAS, Corpus Christi.—Tracing back the causes of fatal accidents in the SNV–1, investigation boards at Auxiliary Air Station, Rodd Field, have found that in most cases the fault is pilot error.

Considering that at least one of the sources of error must have been that the student had not been taught correct recovery methods during his training, 20 stalls are offered in a new syllabus for the Instructors' School.

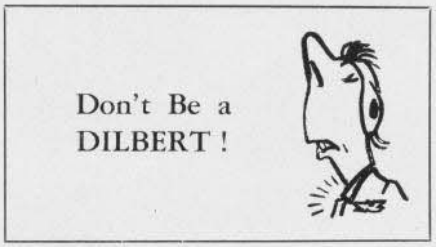
The stalls taught are normal cruising, climbing, climbing turns, normal turns and steep turns, each under four conditions: *1.* Flaps up, sufficient power (1,800–1,850 r. p. m.); *2.* flaps up, insufficient power (1,200–1,400 r. p. m.); *3.* flaps down 20°, sufficient power (1,800–1,850 r. p. m.), and *4.* flaps down 20°, insufficient power (1,200–1,400 r. p. m.). Practically all attitudes and positions of a stalled airplane are shown. The stalling speeds for each of the positions are stressed especially.

The roll-out method of recovery from inverted spins is taught rather than the old split **S** type. Consequently there is less altitude loss and lower airspeed upon recovery.

Included in the syllabus for student officers (instructors-to-be) is a series of lectures on naval customs and uniform regulations, course rules and dual syllabus in the SNV–1 aircraft, radio procedure and radio navigation on airways, safety in flight, constant speed and controllable pitch props, automatic mixtures and icing of aircraft, use of weather maps, student psychology and methods of instruction, three- and six-plane formations, military discipline and courtesies, pay allotments, orders and travel accounts, and standardization of student marks and write-ups.

The student officer is required to keep a notebook which he turns in upon completing the Instructors' School syllabus. The notebook contains psychological facts and hints as well as correct methods of instructing.

BUREAU COMMENT Stalls were involved in 18 percent of all training accidents during 1942. This syllabus should lead to a better recognition of spin characteristics and recovery methods among students.



Machine Guns Accidentally Discharged

NAS, Corpus Christi.—Two recent fatalities caused by accidental discharge of machine guns, recently reported by this Station, demonstrate the necessity of enforcing rigidly all safety precautions.

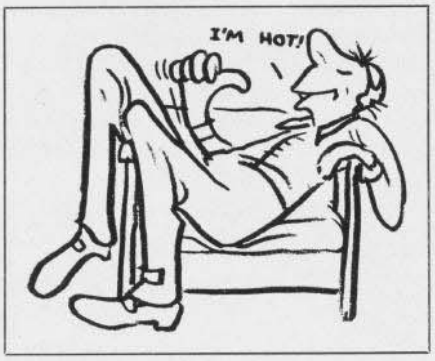
Case 1: A Machinist Mate attached to a squadron of the NAS, CC, was shot and killed while turning the prop of an OS2U–3 seaplane which had been rigged in the status of an alert plane. In securing his plane for the night, the plane captain was engaged in putting on the covers, which necessitated turning the prop into a horizontal position. In so doing, the .30 caliber fixed gun went off and shot him through the head. Subsequent investigation of the ejection-case revealed that there was one dummy cartridge and two links in the case, and empty cartridge in the barrel of the gun.

Leaving convoy duty ready-planes with ammunition in the fixed guns was believed to be a time-saving measure in case of emergency. Instructions were to have one dummy in the chamber and one dummy in the feedway. Investigation revealed that the gun had been loaded about one hour previous to

the shooting by an ordnanceman who testified that he had loaded the gun with only one dummy; however, he explained that he had left the dummy in the feedway, which would leave the gun in the same condition as if he had used two dummies. In order for the gun to shoot as it did (assuming the gun was loaded as described) the charging handle would have had to be pulled twice, the prop moved to a low cam position and the trigger pulled. As warning signs were in the cockpit of the plane and the deceased was seen in the plane prior to the fatal shooting, he should have known that the gun was loaded. It was not determined whether party or parties unknown had tampered with the gun in the one-hour interval when the plane was unattended, or whether the gun was loaded otherwise than as described.

BUREAU COMMENT **See report of a similar accident in *News Letter*, Dec. 1, 1942.**

Case 2: The second fatality occurred as a result of the accidental firing of an M2 .50 caliber Browning machine gun with a Mark II adapter, installed on a PBY–3 plane which had been ferried from another base and delivered to the Naval Air Station, Corpus Christi. The plane was left outside a NAS patrol plane hangar for two days after arrival. On the third day, it was brought into the hangar, and the .50 caliber free gun, which had been in a secured position with canvas cover on, was removed from the plane by two N. A. S. patrol squadron ordnancemen. They immediately thereafter set it up on a bench in the ordnance shack for the purpose of cleaning it. An ordnanceman then proceeded to remove the weather canvas cover. A strip of cloth or lashing, which held the cover secure, passed from the right side of the gun, over the trigger mechanism and around the back plate; and was secured in a grommet of the cover on the left side of the gun. The ordnanceman, in attempting to get some slack on this strip of cloth in order to untie the knot, exerted lateral pressure on the trigger mechanism, thus discharging the gun. A cadet who was standing inside the hangar was killed by a fragment of the bullet which had been deflected in passing through the wired glass bulkhead between him and the ordnance shack. The conclusion is that someone, contrary to regulations, had left a live cartridge in the bore of this gun. The plane ferry crew delivered the plane and installed gun in this condition without notifying the N. A. S., C. C. that the gun was still loaded. A subsequent board of investigation conducted at the N. A. T. C., C. C. revealed that the ferry crew did not know that the gun was loaded when they accepted it for fly-away, and that they did not go near the gun or examine it prior to delivery of plane at destination.



Mechanic Trouble

The pilot of an NE–1 taxied his plane to the line, cut the switch and left the aircraft. Just prior to his return, a mechanic pulled the propeller through to start the engine. The throttle was well advanced; there were no chocks under the wheels, and no one was in the aircraft. When the engine caught, the airplane at once started to take off. The mechanic seized the starboard wing but was unable to maintain his grip and the aircraft became airborne. It failed to clear the boundary fence at the end of the field and was completely washed out in the following crash.

The Trouble Board said: All plane captains on this station have been warned of the absolute necessity for having a qualified person in the cockpit of every plane from the time the engine is started until the ignition has been turned off. Sufficient chocks have been distributed to all outlying fields where it is necessary to park planes for even a short period of time.

Grampaw Pettibone says

This aircraft was lost as the direct result of carelessness and disobedience of orders. Article 13–133 Buaer Manual contains the regulations governing starting of aircraft engines. In this instance, the station concerned had also issued an order on the subject. Evidently a little more indoctrination and pressure is necessary in some cases.

Identify Before Approaching

Reports continue to indicate that frequently United States planes approach United States naval vessels before they have been properly identified. This has resulted in several unfortunate instances and the destruction of some of these planes. Aviators must thoroughly appreciate the fact that the burden of identifying themselves lies solely upon their own shoulders. It is unreasonable to expect the commanding officer of a surface ship to permit an unidentified plane to approach within firing range without giving the order "commence firing." Naval aviators must take every precaution to ascertain with certainty that their plane has been identified clearly before making a close approach upon our own vessels.

Goggles—Up Or Down

Query has been made as to the correctness of the recommendation to "push goggles up on the forehead" in a forced landing (p. 4 of May 1 NEWS LETTER). Although standard goggles are made of so-called shatter-proof glass, they will break and splinter when struck severely. Accident records indicate that numerous eye and head wounds have been caused by broken goggle lenses and even by fractured metal frames. Therefore, the Bureau adheres to its recommendation to push goggles back in a forced landing.

A large number of goggles have been issued having sponge-rubber frames and flexible plastic lenses. These goggles need not be pushed back.

More experience may indicate that the use of the shoulder harness will reduce head and face injuries to such an extent that it will no longer be necessary to push goggles back during forced landings.

Grampaw Pettibone says

That's another thing I'm mad about! I don't believe shoulder harnesses are always being worn. All I say is, talk to someone who has worn one in a crash. And you guys who have used them—proselyte!

Landing Crash Due to Fouled Engine

During his landing approach, the pilot of a PB4Y–1 came in high, but apparently decided he could execute a safe landing by losing altitude in a power-off glide. He completely throttled back the engines until the aircraft was over the edge of the field, at which time he realized that he was still dangerously overshooting. He then applied full throttle, but the engines had become fouled during the long power-off glide, and, upon application of the throttle, they failed to respond. A forced landing was made on the last half of the field, and the bomber was completely washed out when it ran off the runway.

BUREAU COMMENT **Unfortunately, this is not the only serious crash which has resulted from similar mistreatment of the engines by uninformed pilots. Numerous take-off crashes have been attributed to fouled engines caused by prolonged taxiing or idling at low r. p. m. Pilots should familiarize themselves with Article 14–217 of Bauer Manual, which is quoted in part as follows:**

"In a glide an engine must be kept warm; it will not be allowed to go below normal operating temperature and the throttle will be repeatedly opened to clear out the cylinders. When the engine is allowed to cool, contraction of the pistons allows too much oil to be 'pumped' into the combustion chambers and the plugs will be fouled. Prolonged idling of the engine on the ground will cause overheating as well as fouling of the spark plugs."

Hood Failure Plus Pilot Error

The pilot of an FM–1 accepted his plane for flight, knowing that the forward roller of the hood on the port side was out of its track. What happened on his flight is related in his own words: "I had the hood locked open about 2 inches (in the first notch) when I rolled over for an overhead gunnery run on the target sleeve. After diving approximately 2,000 feet and attaining about 300 knots, the enclosure gave way on the port side. I was struck on the right temple and momentarily lost consciousness. Upon regaining my senses, I attempted to release the hood, which was streaming from the starboard side. The release failed, and I then returned to the field and made a normal landing."

The Trouble Board said: Pilots should be cautioned to fully close and lock cockpit enclosures before going into high-speed dives.

Grampaw Pettibone says

Knowing that he was going to engage in violent maneuvers (gunnery runs), this pilot definitely should not have accepted this airplane until the hood operated properly. Common sense is as important to an aviator as flying technique, but unfortunately harder to teach.

Recent Ground Collisions

Case 1. During routine night flying the first student made his final landing, and while taxiing slowly to the end of

the runway was struck from the rear by a second student who had been signaled to land by the Night Flying Operations Officer. Before the damaged second plane could clear the area, another student was signaled to land. This third student landed slightly long, and while still in his landing run, collided with the second aircraft. In the opinion of the Trouble Board the Operations Officer was to blame for these two accidents in that he failed to determine a clear area before signaling additional airplanes to land.

Case 2. Three students were practicing formation flying. After landing at an outlying field, one of the students taxied his airplane through some mud and got stuck. The other two students parked their trainers close by, got out, and attempted to push their unhappy companion free. After much labor on the part of students and engine, the airplane suddenly came loose. In order to keep from miring down again, the pilot added throttle, and while taxiing at greater than normal speed ran into one of the parked planes.

Case 3. While approaching for a touch-and-go landing, a student saw another airplane moving down the runway and assumed that this plane was taking off. He proceeded with his landing and immediately upon contacting the runway applied throttle for a take-off. After lifting his tail, he saw the other aircraft directly ahead of him. An attempt to bounce over the other aircraft was unsuccessful and resulted in a disastrous collision.

Grampaw Pettibone says

Out of this mess of collisions, the Navy lost three primary trainers and had to replace major parts on four others. In the first two cases, the corrective measures are self-evident, but in the last case, which is a very common type of ground collision, there is a psychological factor involved which needs more attention—and that is this business of "assuming" things.

Aviators have no business to "assume" anything. Don't be a "wishful thinker"; don't take anything for granted—check, re-check and double-check. Anyone in aviation who does otherwise just proves the old adage that there are more of "them" than there are horses.

☆ ☆ ☆

I Wuz Robbed

When God passed out brains, I thought He said trains . . .
And I missed mine.
When God passed out looks, I thought He said books . . .
And I didn't want any.
When God passed out noses, I thought He said roses . . .
And I asked for a big red one.
When God passed out ears, I thought He said beers . . .
And I asked for two short ones.
When God passed out legs, I thought He said kegs . . .
And I asked for two fat ones.
When God passed out hips, I thought He said lips . . .
And I asked for two large ones.
Boy, Am I a Mess!

—*From NAS, San Pedro, Calif.*